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ABSTRACT

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Tailoring Inpatient Group Psychotherapy to Patients' Needs: Size Matters!

by

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Tailoring Inpatient Group Psychotherapy to Patients' Needs: Size Matters!

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Abstract

Today's publicly funded psychiatric inpatient institutions focus increasingly on stabilization and relapse prevention, readying patients for community reentry. An increasing emphasis on consumer satisfaction and professionals' accountability for efficient outcomes has coincided with growing cost-consciousness. Therapists must strive to tailor psychological services to the needs of individual patients, in order to address consumer needs appropriately, while simultaneously curbing costs. Staffing limitations mandate creative, flexible use of group methods. Several strategies for individualizing treatment within a cost-effective group context will be presented.

Introduction

As a result of ongoing reductions in staffing complements in publicly funded inpatient hospitals, psychologists are increasingly encouraged to provide group psychotherapy rather than individual therapy. Given the pressures to (1) maintain high levels of consumer satisfaction, (2) provide rapid stabilization of functioning and effective relapse prevention interventions, and (3) include all patients in active treatment, therapists are compelled to experiment with innovative ways of using group psychotherapy methods. Augmenting these already daunting challenges are changes in modal patient characteristics. Patients present increasingly severe and persistent problems in inpatient treatment settings. Thanks in part to managed behavioral healthcare systems, hospitalization is the treatment of last resort, increasingly reserved for cases involving extremely volatile and potentially dangerous behaviors, where risk of symptom exacerbation during the course of treatment is high (Chambliss, 2000).

Addressing these challenges requires innovative applications of traditional interventions (including social skills training, supportive reflection, and cognitive behavioral techniques) and

newer therapeutic approaches (including solution focused methods, pharmacotherapy education, and cognitive engagement techniques). Variable levels of patient functioning often make it difficult to engage all members of groups in collaborative activities. High demands for attention on the part of some group members can prove disruptive to the group experience. Special group strategies are needed to simultaneously meet the needs of active patients requiring a great deal of redirection, the needs of passive, fearful, and withdrawing patients who need to be coaxed to participate, and the needs of eager patients seeking positive shared group experiences.

Because of rapid patient turnover, it is generally unfeasible to develop and maintain homogeneous groups of patients in today's treatment settings. Although empirically supported treatment methods must be provided, it is rare to encounter groups whose members all share the same diagnosis and co-diagnoses. Group composition shifts from week to week, making it necessary to use a modular approach to treatment that does not require continuity which can not be guaranteed. These various realities help to make delivering group psychotherapy in these inpatient contexts both exciting and stimulating; no two weeks are ever the same, and creative flexibility is always necessary. Innovative means of tailoring group meetings to address widely varying patient needs, and to supply various specific treatment interventions are crucial for these treatment settings. This study involved a preliminary assessment of several group techniques designed to offer more individualized treatment experiences within a cost-effective group format. The methods evaluated allow therapists to tailor the shared treatment experience more closely to the specific needs of individual inpatients. Several strategies for individualizing treatment being offered in a cost-effective group format will be reviewed.

Group Strategies for Tailoring Treatment

The first strategy used in this study involves patient selection of group size, through a Mini-Group option within a larger Group. This technique takes a very large group of patients (20-24, depending on the unit's census) and offers members the option of attending either a small (n=3-5) subgroup addressing members' special concerns that day (for example, anger management, eating disorders, self-injurious behavior, sexual abuse issues, substance abuse issues, relaxation training, money management, assertiveness training, etc.) or a large, seminar-style psychotherapy meeting (n=15 and up). The small subgroup may meet only once, or members of it may choose to meet as a small group several times in order to address the same special focus.

A second strategy, Star for a Day, makes one individual the special focus of part of the group session. The individual occupying this special role alternates, so that over several weeks' time, every member gets the opportunity to receive this focused attention. The patient selected is asked to suggest a

particular concern, area of need, or individual treatment objective. Other members serve as therapeutic assistants in helping the leader develop strategies for addressing the individual patient's specific needs.

A third strategy, Peer Mentoring, extends the use of peers beyond the formal group meeting period. Part of the group time is used to plan and structure supportive learning activities for dyads of patients to share in between formal group meetings. Progress in initiating and pursuing these planned activities is assessed at the beginning of each group meeting.

A fourth strategy involves use of Goal Groups, which permit patients to discuss what they need to do while in the hospital in order to facilitate discharge. The psychologist can praise patients who show even minimal progress, and can structure the discussion to encourage mutual support of appropriate behavior. The common goal of discharge unites all members, while the individual obstacles to this goal are being addressed.

A fifth strategy, particularly important in very large groups, is to make use of interdisciplinary interventions. Incorporation of music, art, dance, exercise, budgeting, and cooking activities can help maintain patients' enthusiasm for the large group experience. Providing positive experiences that stimulate various sensory modalities can increase subsequent engagement in more traditional problem solving discussions. In addition, learning how to make positive use of leisure time is important to these patients' eventual discharge success.

Method

Sixty inpatients from three units of a 600-bed state psychiatric institution participated weekly in large (n=15-18 patient members) psychotherapy groups revised to accommodate enhanced individualization of psychotherapy and small (n=3-5 patient members) psychotherapy groups.

Over the course of a 20 month trial period, four anonymous patient surveys were conducted at roughly 5-month intervals in order to assess patient satisfaction with several strategies being used to tailor treatment provided in weekly group psychotherapy meetings. Baseline measures of patient satisfaction with the group treatment program were obtained before the new strategies were implemented. Patient satisfaction was assessed again at 5-month intervals after the techniques had been introduced. Measures of patient behavior within the group program were also collected, in order to assess the stability of patients' group size preferences. Measures of problem behavior episodes on the treatment unit were obtained for both a 5-month pretreatment and a 5-month posttreatment period. Pre and posttreatment comparisons were used to assess the behavioral impact of these attempts to tailor treatment more systematically.

Patient-Selected Group Size

On one of the three inpatient units, each week patients were given a choice of whether to participate in the large (n=12-17 patient members) psychotherapy group or the small (n=3-5 patient members) psychotherapy group. Patients were encouraged to assess their current need for individualized attention and willingness to talk in group, and to select the group size that best suited their needs that day. Patients were thereby enabled to tailor their own treatment experience, based on their fluctuating preferences.

Large Groups Modifications

On two of the three wards, there are not enough staff members to permit patients a choice of group size. Most groups are large (12 to 15 members) and include patients who differ in regard to cognitive skills/deficits, psychotic manifestations, and stability/instability of symptoms. Many of the patients have short attention spans and would not be willing or able to engage in complex discussions.

The large group experience included periodic use of the "Star for a Day" strategy, which makes one individual the special focus of part of the group session. Peer Mentoring was also used to enhance the effectiveness of the very large group sessions. It encourages the development of mutually supportive patient dyads, to extend the work of the group beyond formal meeting times, and to provide practice in maintaining positive social bonds.

In each patient's treatment plan, the basis for all activities on the ward, there are listed short-term objectives that the patient is supposed to accomplish as steps toward a long-term goal. The goal in each case is based on controlling the problem that caused the present hospitalization. Many of the patients were hospitalized because their behavior made them unacceptable to the group homes in which they had lived. Goal Group sessions were used to permit patients to discuss what they need to do while in the hospital in order to facilitate discharge. The objectives in these cases might involve accepting reality-based feedback from staff demonstrating appropriate social interaction with peers. Some patients have difficulty in focusing attention long enough to handle the ordinary personal and interpersonal activities of daily life. The objectives in these cases might involve focusing attention long enough to proceed with a task or topic for a certain period of time (e.g. five minutes).

In order to provide a positive experience for each patient, and to work toward accomplishing the objectives, the therapist needs to be flexible in choosing programs, presenting topics and tasks, and encouraging appropriate interactions. Often it has proved valuable to utilize the services of therapists from more than one department, to give patients a variety of experiences within a group. For example, the psychologist has led a half-

hour discussion, then encouraged and joined exercises led by an occupational therapist. The group then had music and discussion, co-led by a music therapist and the psychologist.

Results

Measures of patient satisfaction showed that group members preferred the more individualized approaches to conducting group psychotherapy meetings. Attendance improved following incorporation of these techniques for accommodating patients' individual needs and providing tailored learning experiences within the group. On one of the units evaluated, during the five months following the initiation of the trial period (during which these techniques were incorporated into group meetings), the majority of patients chose to attend the small size group on at least three occasions (80%). Only two patients refused to try the small group at all. Preference for the small group opportunity was very consistent for some patients (during one 5 month period, two patients in particular chose the small group every single week). During the 20 month trial period, there was considerable rotation of patients between the small and large groups. This suggests that they did try to match the therapeutic experience to their particular needs on that particular day. When asked about factors influencing patients' group size choices, several patients said that they knew that on some days they needed to talk a lot and would have difficulty being patient with the frustration of waiting for their turn in the large group. The fact that the small group reduced the frustration experienced by patients when they were "having a bad day" may have contributed to a modest reduction in the number of self-injurious and assaultive behavioral episodes from pre-treatment to post-treatment periods.

One of the unforeseen advantages of this system of dual group delivery was that it seemed to help curb symptom contagion. When one patient began behaving in a recurrently self injurious manner, she was encouraged to select the small group, and only patients with little risk of imitating her choices were encouraged to attend the small group during this period. In the past, when such patients were integrated into larger groups, their apparent success in obtaining special attention from staff often contributed to a rash of similar acting out on the part of other patients. Pairing a small and extra large group, rather than using two medium sized groups, seemed to reduce this risk.

The strategies that were used to modify the large group meetings succeeded in providing needed social stimulation for both low-functioning and high-functioning patients, and gave patients many opportunities for guided interactions. Patient attendance and participation rates improved after implementation of new techniques aimed at enhancing patient engagement. The majority of the patients could remember at least some of the words and music of songs they had learned as children or adolescents, and could join in singing familiar numbers. After

each song, the psychologist encouraged reminiscences and then led a group discussion that often involved the content of the song as well as memories associated with it.

This program was satisfying to the participants and led to progress toward the patients' treatment objectives. High-functioning patients were helped to provide assistance to their lower-functioning peers, who in turn expressed satisfaction about what they had been able to remember. Outside of formal group meetings, the peer mentoring approach resulted in the creation of several mutually supportive patient dyads (for example, one woman who loved to cook took a recovering anorectic patient who wanted to learn healthful recipes under her wing; in turn, the cooking student taught her mentor the basics of word processing).

Discussion

These findings suggest that some of these strategies for offering flexible group experiences (either patient-selected group size, or large group modifications) may be a practical way of improving treatment delivery while working within budgetary constraints. The patients seemed to welcome the efforts made to address their individual treatment needs more systematically. However, several factors limit the conclusions that may be drawn here. First, the reduction in the number of self-injurious and assaultive behavioral episodes may have been an historical artifact, because the trial period coincided with a shift to greater reliance on symptom-focused pharmacotherapy on the part of unit psychiatrists. The resulting changes in patients' medications may have actually accounted for their improved behavior. In addition, since no wait-list or placebo control group was employed, only limited inferences about the causal impact of the incorporation of these strategies are warranted here. Furthermore, a lengthier sampling of behavioral episodes is needed to draw more confident conclusions about the impact of these group strategies on this challenging population. However, these encouraging preliminary findings suggest the need for more rigorously controlled extensions of the current work.

An increasing emphasis on consumer satisfaction and professionals' accountability for outcomes has coincided with growing cost-consciousness in publicly funded psychiatric inpatient institutions. This has produced a need to offer more customized services, while simultaneously constraining costs. State psychiatric hospitals have long relied on group delivery of psychotherapy in order to meet the needs of a large number of patients with a limited staff of psychologists.

In recent years, the expectations of group therapy have increased, forcing group therapists to be more inventive. Therapists are expected to use empirically supported treatment methods, and to evaluate their effectiveness by monitoring individual patient outcomes. Effecting measurable behavioral change has supplanted providing support as the goal of treatment. Maintaining stable functioning within the institution is no

longer seen as sufficient; therapists are expected to help patients develop and implement specific new skills. Escalating pressure to discharge patients more quickly has also compelled therapists to develop more effective techniques.

Today's hospitals are expected to provide care for an increasingly challenging population of inpatients, without use of seclusion or restraints. Deinstitutionalization, coupled with behavioral healthcare organizations' avoidance of costly inpatient treatment, have challenged these institutions by changing the modal characteristics of the psychiatric inpatient population they serve. As symptom severity and level of impairment have replaced diagnosis in determining patients' level of care, self injurious and other violent behaviors provide the basis for an increasing number of hospitalizations. This has resulted in a growing concentration of patients with a history of violence in many inpatient psychiatric facilities. The demand to treat these difficult clients in a short time frame, using least expensive methods, keenly challenges the creativity of those working in the public sector. The group therapy methods described in this paper provide some suggestions for ways to serve patients' needs under increasingly taxing circumstances.

References

Chambliss, C. (2000) Psychotherapy and Managed Care, Allyn & Bacon, Boston, MA.

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